Lectures
ON VENEREAL AND OTHER DISEASES
ARISING FROM
SEXUAL INTERCOURSE.

Delivered in the Summer of 1847, *at the Hôpital du Midi, Paris.*

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(*Specially Reported for* The Lancet, *at the Hôpital du Midi, by* Victor de Meric, M.D., M.R.C.S.E.)

LECTURE XII.

VAGINAL BLENNORRHAGIA.

This is, in fact, a vaginal blennorrhagic catarrh, and is of very common occurrence. The inflammation is mostly superficial, but it may occupy the follicles, the whole thickness of the mucous membrane, and the sub-mucous cellular tissue. The symptoms are, heat and pain, greatly increased during defæcation and micturition, and more or less unfitness for coïtus. Yet, you must bear in mind that this vaginal blennorrhagic catarrh may set in and continue for some time without attracting much attention on the part of the patient. The disease is often confined to that portion of the vaginal mucous membrane which is reflected on the cervix uteri, and it then bears much analogy with balano-posthitis in man, which, as you know, occupies the cul-de-sac formed by the reflection of the mucous membrane of the glans on the prepuce. When the whole vagina is engaged, erosions and granulations soon follow the redness of the part, pus may be detected in the discharge, and the granulations may increase to such a degree as to assume the character of vegetations. The tricomonas* has been discovered in the pus, and its presence has by some been looked upon as depending on the specificity of the disease; but I cannot admit this, for we do not find it, in the discharge of the male urethra, brought on by the contact of this very vaginal pus. The matter finds a ready exit with women who have had children; but with others it will be necessary to make a manual examination, to ascertain its existence, as it accumulates in the vagina, and never appears at the vulva but on defæcation or micturition. Whenever it is desirable, for some reason or other, accurately to trace the part whence the discharge arises, the speculum should be used, except during phlegmonous vaginitis, or excessive sensibility of the organs. But when this sensibility is unconnected with inflammation, you must gradually accustom the parts to the contact of foreign bodies by pledgets of lint &c., and by cautious increase of their size you will succeed in accomplishing the tolerance of the speculum. Not a very long time ago it required a consultation of three medical men to decide upon its application; but in our days it is in common use, without any such preliminaries; still I would advise certain precautions, which you will do well to remember. Leave your patients the free choice of the persons who are to be present; always insist upon the assistance of a third party; avoid making unnecessary preparations, and do not resort to anything like entreaties, but show firmness. Let the speculum be warm, and well anointed, and use the bivalve variety. I have had one made, in which the pivot on which the valves turn corresponds to the entrance of the vagina, a part which is the least sensitive of the whole canal. The index and middle finger of the left hand are applied to the sides of the fourchette, and the ring-finger depresses it; the closed speculum is placed on a level with the plane of the vagina, and rests on the ring-finger. As you pass along the canal, you turn the valve on your right, superiorly, and to your left; the other valve lies in the opposite direction. By this turn, you bring the greater diameter of the instrument on a level with that of the vagina. As you advance along the latter, you must turn the handle of the speculum towards the patient's left thigh, so that one of the valves may correspond with the anterior part of the vagina; the other with the posterior. When you get near the cervix, (the exact situation of which is ascertained beforehand, by a manual examination,) you may withdraw a little, and in pushing slightly forward, the valves will seize the neck of the uterus as the cup takes hold of the ball in the toy so named. In this manner you will get a good view of the parietes of the vagina and the cervix, and be able to withdraw the instrument without the slightest injury to the part.

* Tricomonas—a name given by M. Donné, in 1836, to an animalcule found in the pus of vaginitis. He named it thus, as he thought it resembled the monas by its trunk, and the trichoda by its cilia.

Treatment.—The abortive means which I have mentioned so frequently may do exceedingly well here, when we are applied to early. It will consist, as you know, of strong injections of nitrate of silver, or brushing the part with the same salt in a solid state. I was the first to use this treatment in vaginal and uterine blennorrhagia. Glass syringes should be used for the injections, and the pelvis kept elevated, for the liquid would otherwise hardly penetrate, and would run out as soon as injected. See, also, that every trace of the solution be carefully cleansed away, to prevent indelible stains on the linen. When you use the solid nitrate, introduce it as far as the neck, and withdraw it on touching the parietes of the vagina in a spiral manner. Rest, and low diet, added to this treatment, will, in most cases, be sufficient to effect a cure.

The keeping the inflamed surfaces asunder by plugging was introduced by me originally, and has since been much recommended by Hausmann. I perform it generally by means of a small bundle of lint, to which a thread is connected; the latter is allowed to hang out of the vulva, and the patients can change the plug, when saturated, without being in need of any assistance. But we are seldom consulted at an early stage; advice is sought when the parts are ready to run into a phlegmonous state. We must then at once energetically use antiphlogistics, emollient and sedative injections, as bran-water, mucilage of quince or linseed, and fomentations of poppy-heads, &c.; but be careful to apply the leeches on a part not likely to come in contact with the muco-purulent matter, for the co-existence of a concealed chancre might cause a syphilitic inoculation. As soon as you have got rid of the acute symptoms, it will be advisable to prescribe the astringent injections—viz., a solution of nitrate of silver, two parts of the salt to one hundred of water; to advise rest of the generative organs, and the exhibition of steel. Alum, acetate of lead, and sulphate of zinc, may also be used as injections. In chronic cases, I find it useful to plug the vagina with lint, imbibed with astringent solutions; and when the discharge continues very obstinately, I look for granulations or ulcerations, which I destroy forthwith with the solid nitrate. Mere hypersecretion, which is often a sequela of vaginitis, may be controlled by any mildly astringent or tonic injections, as a decoction of walnut-leaves &c. Copaiba and cubebs, taken internally, are of no use here; the mode of action of these substances, on which I dilated some time ago, sufficiently accounts for this. M. Piorry has tried the injection of both drugs, mixed with water, or other menstrua, but obtained no satisfactory results. Remember, when your patients are convalescent, to advise a continuance of injections of cold water, sea-bathings, &c. If you notice that you have to deal with scrofulous, lymphatic, or chlorotic subjects, you must use means to modify these different states, for they are extremely prone to keep up the discharge.

Uterine Blennorrhagia.—It is now proved that blennorrhagia may reach the uterus, and even run along the Fallopian tube to the ovary. There is no difference between simple uterine catarrh and uterine blennorrhagia, so that I need not insist upon the description of the latter disease. I will, however, trouble you with a few words about the consequences of it—viz., hypertrophy of the mucous membrane, granulation and ulceration of the cervix. These do not constitute distinct symptoms of uterine blennorrhagia; they are mostly owing to a peculiar pathological state of the surfaces. It has long been held that they were the result of the irritating nature of the uterine discharge, just as herpes labialis is the result of coryza, and it was moreover alleged that the posterior lip of the os tincæ was more often affected, as being more constantly in contact with the secretion. These views are not correct; for, in the first place, we often find ulcerations on the anterior lip, and secondly, were we even to grant that the discharge does the mischief, it would remain to be proved that the posterior lip, except in the dorsal decubitus, is the lowest part of the os, for in the standing or sitting posture the fundus leans forward, and the anterior lip becomes thereby the lower one. Yet, without denying *in toto* the influence of the discharge on these ulcerations, I am more inclined to attribute them to the pressure which the posterior lip experiences from the recto-vaginal septum, in women with whom constipation is an habitual state, and whose rectum contains scybala. Notice that these erosions are irregular in shape and not circumscribed, whilst a chancre in this situation, as in all others, would be more or less regular and isolated. Baglivi has tried to aid us in the diagnosis between blennorrhagic vaginitis and uterine catarrh, asserting that the latter is essentially chronic, and the former acute, but it is no such thing; it is lucky, however, that we have nothing to do with the causes in order to effect a cure, for as soon as the in-

flammation of vagina or uterus is developed, we must pay attention to the symptoms before us, and act in accordance with them. The only distinction which it is important to make, is to find out whether we have simple blennorrhagia and chancre to deal with.

Treatment of uterine blennorrhagia.—If you are consulted in time, use the abortive treatment; here, however, I prefer the solutions of nitrate of silver to the solid salt, for with the latter we succeed in touching but a few points of the affected surface. It was with me that injections into the cavity of the uterus originated. I have used a great variety of them—viz., nitrate of silver, the liquid nitrate of mercury, iodides, alum, zinc, and emollient solutions, and I have never witnessed any serious accidents from them. But still it must not be overlooked that very fearful hysterical symptoms may follow such injections, and they may completely simulate an attack of metro-peritonitis. These frightful manifestations will subside altogether in a couple of hours. It has been contended that the injection might escape in to the abdomen,—and experiments have been made on the dead subject to prove this,—but the liquids were thrown in with such force, that they would have ruptured the uterus if they had not entered the Fallopian tube; and besides, the absence of contractility in the dead fibre must also be taken into consideration. I make the injections in the following manner. A very small canula is introduced within the neck of the organ, and it must be so small that it may move quite freely in the cavity of the cervix; as much liquid as a common tea-spoon will hold is then pressed gently into the uterus; it moistens its mucous membrane, and flows back again by the sides of the canula and the tube connected with it; it is therefore quite impossible, in this manner, that any part of the injection should pass along the Fallopian tubes. M. Vidal, one of my colleagues, has repeated these experiments, and used the same solutions; in the account of them, he has, however, forgotten to mention whence they originated. If it is desirable that none of the liquid remain within the uterus, you must use a double tube, to allow of a current to and fro. Another mode, which I have found very useful, is, to place a small sponge soaked in the medicated liquid within the cervix; the solution is then squeezed out by pressure on the uterus, and is diffused through the cavity without giving rise to the symptoms which injections are apt to bring on. I have known the disease persist in spite of all these means, and indeed the uterine, howsoever produced, are the most tenacious discharges of all; search must then be made for ulcerations on the neck of the uterus, and if found, cauterize them with the nitrate of silver or the liquid nitrate of mercury. These caustics may even be carried within the cavity of the cervix, but before applying them, care should be taken to remove the muco-purulent matter, which, in the uterus, is very dense and adhesive, whilst the secretion of the vagina is generally thinner. M. Récamier has proposed, in cases of persisting discharges, combined with a fungous mucous membrane, to introduce a curette into the uterus, and scrape the parietes; and Hausmann advises to plug the vagina under the same circumstances. In fine, you will do well to use your best exertions to free your patients from this distressing complaint, and to effect this you must not only attempt all the means I have enumerated, but likewise look to their general health, to the enforcement of hygienic measures. As to the latter, you must see that the wearing of thin shoes and stockings in damp weather, and sudden changes from a dry and warm abode to a cold and damp one, be carefully avoided, and warmth to the legs and feet be duly attended to.

Blennorrhagic affection of the ovary.—This is very rare: it may be sympathetic, or the result of an extension of the inflammation through the Fallopian tubes by the mechanism of conception. The symptoms are, pain in one iliac fossa, or in both, as also in the hypogastric region; if, during a vaginal examination, the uterus be pushed to the side where the pain is complained of, the latter diminishes, as by this displacement the ligament is slackened; but if the uterus be pressed to the opposite side, the tension of the ligament will increase the pain. M. Vidal has observed cases of blennorrhagic ovaritis at the Hôpital de Lourcine, (the Paris Lock Hospital,) but I can offer you no *post-mortem* examinations on the subject. It appears that the disease generally terminates in resolution. I am rather disposed to think that many ovarian dropsies and other affections of this organ may have blennorrhagic ovaritis as their primary cause. Let me mention, in conclusion, that this disease is exactly the analogue of epididymitis.

Anal blennorrhagia.—This is extremely uncommon, although muco-purulent discharges from the lower part of the rectum are of frequent occurrence; but these are generally caused either by hæmorrhoids, eczema, or prurigo ani. An unnatural connexion with such predispositions is very likely to bring on a discharge which has nothing to do with blennorrhagia; but the latter disease, engendered by actual contagion in this region, is excessively rare, particularly as the mucous membrane here is not very sensitive. The disease is ushered in by heat and itching in the part, difficulty of defæcation, &c.: if the affection remain unchecked, the constipation becomes more painful, and perinæal abscesses form. The passage of fæcal matter is calculated to keep up the disease, but I have generally succeeded in controlling it in those cases which have come under my care. At the onset, I cauterize superficially with the nitrate of silver, and throw up injections of cold water; to this I add mild purgatives, as magnesia or sulphur; and in the phlegmonous stage, antiphlogistics and emollients are to be used, as I several times have had occasion to mention. Nasal and buccal blennorrhagias have been admitted, but their existence is far from being proved; people affected with blennorrhagia may experience an attack of coryza without the nasal secretion being necessarily of a blennorrhagic nature. The buccal variety is just as hypothetical; at least, I have never seen it, and yet, if such a thing existed, it would be the most easy of detection.

Blennorrhagic ophthalmia.—I will enter this day upon a very interesting topic—viz., blennorrhagic ophthalmia. This is a very fearful disease, and one which ought to be combated with the greatest energy. The general opinion is, that ocular blennorrhagia is exclusively the result of the direct application of the pus to the eye. I myself thought so once, but experience has made me alter my views on this subject. Remember that purulent ophthalmia occurs only with urethral blennorrhagia, and that balano-posthitis, vulvitis, and uteritis, never produce it: this is a very curious fact. Yet vaginitis, simple uteritis, and vulvitis, may bring on urethritis, and the latter may *then* engender blennorrhagic ophthalmia; it seems as if there were something peculiar in the inflammation of the urethral mucous membrane. Another fact is, that this ocular affection is more frequent in men than women. So, then, we start with two well-settled points—viz., blennorrhagic ophthalmia is always connected with *urethral* blennorrhagia, and it is more frequent in the male than in the female sex.

First variety: blennorrhagic ophthalmia communicated by contagion.—It is a fact beyond doubt, that pus resulting from urethral blennorrhagia applied to the conjunctiva produces blennorrhagic ophthalmia. It has been said that the pus never reaches the globe of the eye, and is generally applied to the eyelids only; but it is obvious that a very small extent of conjunctiva coming in contact with the pus by the play of the eyelids is sufficient to spread the disease. The urinary functions are likely in one sex to cause the hand to be soiled with pus, whereas in the other it is not the case; hence the greater frequency of the affection among men. Look at newborn children; does not the contact of the puriform matter of the uterus and vagina with their eyes engender a great many blennorrhagic ophthalmias? Those who will needs ascribe the affection before us to a general disposition, acquired by the effect of the disease on the system, have had their patients watched very closely during the whole day, and observed the most scrupulous cleanliness, and still the eyes became affected; but who knows whether these restrictions were enforced at night? I cannot admit such cases as having any weight in the question; and besides, there are some others which it is impossible to explain on mere constitutional influence. For instance: a blennorrhagic patient loses both eyes by an ophthalmia of the same nature; his brother, who slept with him, experiences the same ocular affection, but gets cured, and not the slightest discharge from the generative organs could be found. Is not this direct contagion? A woman by accident used, as a wash for her eyes, a solution of acetate of lead, which her husband, affected with urethral blennorrhagia, had unfortunately been employing as a lotion; violent ophthalmia came on, and on examination she was found quite free from any discharge whatsoever. Welsh admits all this, but denies auto-contagion. He says that he has seen the blennorrhagic pus of a patient applied to the subject's own eye without doing any harm. This case goes for nothing; for there must be, beforehand, a certain predisposition in the eye to take the disease, even when exposed to contagion. The muco-purulent matter secreted by the conjunctiva, being applied to the urethra, will give rise to urethritis; this fact has even led some to think that urethritis was the result of Egyptian ophthalmia; whilst others have contended that Egyptian ophthalmia was, on the contrary, the result of urethral blennorrhagia, and that the ocular affection had spread from the eyes of one individual to the eyes of another. There is, in fact, so much similarity between these

diseases, that it is difficult to decide which was the original affection. This variety of blennorrhagic ophthalmia occupies, generally, but one eye; yet the other may suffer, either by sympathy or the contact of pus. This last mode of transmission is pretty frequent, since patients are very apt to lie on the sound side, to avoid pain, and they thereby favour the trickling of the matter from the inflamed eye to the healthy one, particularly those whose ossa nasi are rather depressed. The ocular disease may be communicated by contagion, when the blennorrhagia is merely of a few days' standing, and the eye may suffer severely without the organs of generation being affected in the least: indeed, I cannot help thinking that many of the purulent ophthalmias which we receive in our hospitals have very often urethritis as their primary cause. As for the disease spreading by a sort of aura blennorrhagica, I must say that such a thing is quite improbable, for there would be very few patients of this house who would escape ophthalmia, living, as they do, in a regular blennorrhagic atmosphere.

Second variety: metastatic blennorrhagic ophthalmia.—It is generally acknowledged, that there are patients who suffer from the ocular disease, as a result of urethral blennorrhagia, quite independently of contagion. I am ready to agree to this, not because I am told that these individuals could not possibly carry the pus to their eyes, for there is no certainty about this, but from the aspect, rise, and progress of the disease. I may notice here, that blennorrhagic ophthalmia, which springs up without contagion, is often connected, although not necessarily so, with a rheumatic diathesis.

Having now stated the two varieties I acknowledge, I can take up the symptoms of the first. I have already stated, and I must repeat, that a discharge of a very recent date may contaminate the eye; and, moreover, that the infecting properties of the pus are retained for months afterwards; in fact, as long as the matter remains irritating. I am, of course, understood to speak of the muco-purulent discharge of *urethral* blennorrhagia alone, both as to the variety by contagion and by metastasis. Ophthalmia by contagion is very rapid in its progress; it attacks usually one eye only, but the other may suffer consecutively, whether by sympathy, contact of the matter, or metastasis. Some patients experience first great heat in the eye, others pruritus; they soon complain of a sensation of sand in the organ, the conjunctiva gets vascular, but the inflammation is still confined to the mucous membrane lining the lower lid; it then reaches the inferior oculo-palpebral sinus, and thus it ascends towards the upper lid. The matter secreted is at first mucus, and afterwards it becomes muco-purulent. There is no secretion at the very beginning; but this dry period is so short, that it mostly passes unnoticed. The whole eye, as I mentioned, is not invaded at once; but the entire organ soon gets involved; the mucous membrane is injected, and turns of a brick-red; the inflammation attains a high degree of intensity; the temple and eye experience as yet little pain; the lachrymal secretion is abundant, bursts forth in gushes, and causes a severe scalding—the analogue of ardor urinæ; the sub-mucous cellular tissue gets involved in the mischief, and presents at first simple, then phlegmonous, œdema; it is quite a repetition of balano-posthitis; the lid swells, becomes convex, reddens highly, and looks erysipelatous; its own weight bears it downwards, and causes it to cover the lower lid, which latter is thus pressed against the globe of the eye; real trichiasis ensues, which tends to increase the irritation; if the lower lid should likewise swell, then will its margin be on a level with the tumefied upper palpebræ, and ectropium is often the result of this state of things. The infiltration soon invades the whole of the sub-mucous cellular tissue, the puffed-up mucous membrane forms a thick rim around the cornea, and we have chemosis. As the disease proceeds, pain in the head comes on, and phlegmonous symptoms appear. There is but little intolerance of light at this period; but the deeper parts of the organ at length begin to suffer, and the cornea begins to suffer. The appearance of the secretion passes through the same stages which we noticed in urethral blennorrhagia; it is first of a light-yellow, gets then a little deeper, then brownish, and in bad cases, sanguineous and very thick. We shall see a little later how the nature of the pus has been taken advantage of to aid the prognosis. The two palpebræ may get quite glued together, and they form internally a cavity, where the pus and tears lie stagnant. The eye remains in contact with these irritating substances, and the disease is so much the more destructive as the palpebral aperture is narrower; whilst balano-posthitis is just in the same way the more troublesome as the *preputial* opening is smaller. Patients do not find their sight impaired up to a certain period of the disease, and the cornea is perceived clear and brilliant in the middle of the conjunctival swelling; but it is at last attacked also, after a resistance due to the difference of texture. It loses its transparency; a plastic effusion takes place; it becomes twisted and of an opal colour; it softens, and little purulent deposits form between its layers; these abscesses burst either externally or internally, and more or less complete perforations ensue, the consequences of which vary according to their size and the nature of the substances injured. The cornea is with some patients very quickly destroyed; it perishes in some degree forthwith, particularly when the chemosis is fully developed. The inflamed parts undergo transformations which you should be acquainted with; the mucous membrane assumes a granular and rugged appearance; the granulations become larger as the disease advances; but they attain a considerable size only in cases of long standing, and which have been neglected. The ophthalmia can run through all its stages, destroy the eye, and spread to the internal parts of the organ in twenty-four or forty-eight hours, but it takes mostly five or six days. If the disease have resulted from contagion, and if one eye only is attacked, the progress will be the faster; and when nothing is done to stay the mischief, the eye is sure to be lost. The favourable signs pointing to the decline of the inflammation are the decrease of size in the lids, the cessation of febrile symptoms, the diminution of the secretion, its change from pus to muco-purulent matter, the fading of the redness, the lessening of the chemosis, and the easy separation of the lids. If the affection has been transmitted by contagion, there is no danger of a relapse; it does not kindle again at the slightest provocation, as we find it doing in cases of metastasis.

Differential diagnosis.—The principal guide to the diagnosis is the existence of a urethral blennorrhagia or contagion from one individual to another. There is no sign, except these two circumstances, which may assist the inquirer in distinguishing this disease from Egyptian ophthalmia; the general aspect of these affections, their progress, the nature of the pus, their intensity, are pretty much the same. Some importance has been attached, by M. Lerios, to the swelling of peri-auricular glands, as pointing to non-virulent affections; but dwelling upon these signs is of no use, since there is no such thing as virulent blennorrhagia.

Prognosis.—This is in general unfavourable. Mr. Lawrence states that the eye was lost in nine cases out of fourteen. Whilst I was an *interne*, under Dupuytren, I never saw one eye saved, the perforations always destroyed the organ; but matters have changed for the better since that time, and we now preserve as many eyes in this disease as we lost at that period. The surgeon must watch his patient closely, and he will be amply remunerated for his trouble, by the satisfaction he will feel in saving a valuable organ placed in such jeopardy.

Besides the varieties of blennorrhagic ophthalmia hitherto mentioned, there is one alleged to spring up as a consequence of a constitutional blennorrhagic infection. I have only to state that it can have no existence, since we do not admit of a constitutional taint being ever the result of blennorrhagia properly so called.

Third variety: sympathetic blennorrhagic ophthalmia.—When one eye is affected by contagion, the other may partake in the disease, independently of purulent contact, and of the state of the constitution. This may readily be admitted, since we often see a simple ocular inflammation of one eye, without any secretion, pass to the other, when contagion, metastasis, or the general state of the system, are out of the question: and do we not sometimes see these phenomena occur after the operation for cataract performed on one eye only? Authors have admitted an ophthalmia sympathetic with articular inflammation, but I think this the mere coincidence of a catarrho-purulent ophthalmia, or an effect of a general state of the system favouring the development of catarrho-purulent inflammation of several mucous membranes at the same time as the urethral or the ocular. But in the greater number of cases there is another and very remarkable diathesis in the system—namely, the tendency to rheumatic inflammation; and many blennorrhagic ophthalmias spring up under its influence. Abernethy admitted an irritative state of the constitution, to explain the occurrence of the ocular affection; these rheumatic ophthalmias have, in later times, been attributed to metastasis. The origin of this latter opinion may be found in the moveable and oscillating character of rheumatism. But, I might ask, is metastasis acknowledged for rheumatism itself? I am afraid we must accuse strumous, lymphatic, and gouty constitutions more than

metastasis. Some authors have thought that the mischief is caused by the use of balsams and injections, but I repeat here what I said before, about epididymitis—namely, that most of those who suffer both from the testicular and ocular affections, have used no treatment at all. In fact, there are patients who, with every blennorrhagia, experience gouty and rheumatic pains, and even blennorrhagic ophthalmia, showing plainly that these different and simultaneous affections depend more on a peculiar diathesis than on metastasis. The ophthalmia under consideration may result from a mere gleet, and it has been observed that both eyes are mostly affected in these cases, either together, successively, or alternately. This fact militates greatly with the attempt that has been made to establish a distinction between blennorrhagia and Egyptian ophthalmia, in saying that one eye only was attacked in the former, and both in the latter. You remember that I stated that in blennorrhagic ophthalmia, by contagion, one eye only is most frequently affected.

Duration.—This variety lasts much longer than the disease arising by contagion; it is more subject to relapses; passes easily from one eye to the other, as we have seen epididymitis pass from one testicle to the other; and is very often accompanied by articular inflammations. This arthritis may either succeed or precede it, or spring up at the same time; oscillations between the ocular and urethral blennorrhagia are sometimes noticed; and, indeed, ocular and urethral blennorrhagia, as well as the articular affection, may very well co-exist.

Symptoms.—When the morbid agent acts upon the whole of the ocular mucous membrane, we have pretty nearly the same symptoms as with the ophthalmia from contagion, and it is very difficult, at the very onset of the disease, to distinguish one of these varieties from the other. But the difference soon becomes apparent; the vessels of the sclerotica get injected, the globe of the eye is tender and painful, and the pain reaches very deep; the colour of the cornea changes, owing to the inflammation of the membrane which lines its posterior aspect; the iris soon partakes in this discoloration; the secretion of aqueous humour increases remarkably; and a sort of hydr-ophthalmia takes place. Photophobia comes on, and if the inflammation penetrates more deeply, there may be photopsia; the secretion of tears is much augmented; and an effusion of an albuminous liquid takes place in the anterior chamber. From this you perceive that in this sympathetic blennorrhagic ophthalmia there is as little tendency to suppuration as in rheumatic arthritis; indeed the inflammation of the membrane, secreting the aqueous humour, may well be compared to synovitis in the joints. Still there may be very unpleasant results from the inflammation of the iris in this variety; puckering, permanent contractions, and irregularities of the free margin: and even real cataract from pseudo-membranes formed by the morbid secretion, may remain permanently. The disease generally begins by a catarrhal state of the conjunctiva, and then extends to the iris, but the globe itself is sometimes attacked first.

Prognosis.—If catarrho-rheumatic ophthalmia be not immediately recognised, and properly treated, it may turn out a very serious business; but when it is well understood, and adequate means are used to control it, there is much less danger than when the disease has been transmitted by contagion. Suppuration and the destruction of the eye is then much less to be apprehended. I have not time to enter upon the treatment of blennorrhagic ophthalmia; I will do so at our next meeting, when I hope to begin blennorrhagic arthritis.